FAQs

Care Select is the new care management program created by the Indiana Family and Social Services Administration (FSSA) to serve Hoosiers who are aged, blind or disabled. *Care Select* will:

- Tailor benefits to people who are aged, blind or disabled more effectively
- Improve the quality of care and health outcomes
- Control the growth of health care costs
- Provide a more holistic approach to member's health needs.

Questions from five Community Meetings and several Advocacy Meetings held in preparation for the initial implementation of *Care Select* were gathered by the *Care Select* Outreach Team. Answers to these questions are provided below. To view a specific category of questions and answers, press "CTRL" and click on the name of the section you wish to view. If you have additional questions, please submit them directly to the *Care Select* Program at careselect@fssa.in.gov.

Frequently Asked Questions - Categories

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Care Management

1) **What is included in the Care Select "holistic approach" to care coordination**? Care Select will take into consideration the concerns and responses of all stakeholders in a member's care. To that end, it will be the perspective of the member, their families and advocates, Primary Medical Providers (PMPs), specialists, Care Managers, Case Managers, etc. (115)

2) **How will the multiplicity of care managers and case managers for a given patient coordinate in Care Select**? The Care Management Organization (CMO) is responsible for coordinating and communications with all stakeholders in a patient's care to ensure an integrated approach to the health care of each member. (49)

3) **Will there be coordination with Community Mental Health Center (CMHC) Case Managers**? Yes. (63)

4) **Will the Division of Family Resources (DFR) Case Workers be trained on Care Select?** The Office of Medicaid Policy and Planning (OMPP) is providing and will continue to provide training and outreach to all stakeholders affected by the Care Select Program. To that end, information will be shared with these case workers as well. (78)

5) **Can a member receive services from both Clarian and St. Vincent's?** Yes, with proper coordination and referrals through the PMP. (81)

6) **What is the caseload limit for Care Managers?** Members will be assessed into a Level (one is lowest, four most acute). Care Managers will have a mix of levels to support and will operate with a team approach. Approximately 10% (7,000 statewide) of the population requires Level 3 or 4 care. (83)

7) **Will members be required to call the Care Management Organization (CMO) in order to visit their PMP?** No. Members will be able to contact their PMP directly for appointments. (95)

8) **Will the CMOs limit folks who think they need to see their PMP too often?** The Care Select Care Managers will be in tune with the members' PMP visits as well as whether they are appropriate. (95)

9) **Will Restricted Cards continue?** Restricted Cards will continue in the Care Select Program. (95)

10) **What qualifications are required to be a Care Manager?** The Care Management staff must include qualified case managers who are registered nurses and/or licensed practical nurses, social workers, therapists, physician assistants or other appropriately qualified individuals. (116)

11) **Will MDwise and ADVANTAGE behave consistently from the client facing perspective? For example: Will a provider who is a member of both CMOs interact the same way with both?** The CMOs are coordinating very closely with the State as well as with each other to prevent as much confusion as possible. Over time, there could be different value added programs for the two CMOs; however, there will not be a greater administrative burden placed on the PMPs. (9)

12) **Can a provider refuse to serve a patient?** Acceptable reasons for reassignment requests to a different PMP are: medical needs could be better met with a different PMP and/or breakdown in physician/member relationship. (11)

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Care Plans

13) **How will the CMOs prepare the Care Plans?** There are essentially two teams who will work on the Care Plans: 1) the CMO's internal core team and 2) the CMO in coordination with other providers. In addition, members will be assessed into care levels in order to ensure needs are met by a team with appropriate qualifications. (145)

14) **What is the expected timeframe from initial enrollment to completion of the initial assessment?** The target is thirty days. The contractual performance metrics require 95% of all initial assessments to be completed within thirty days, assessments of care level within sixty days and comprehensive plans to be completed in ninety days.

15) **How often will Care Plans be reviewed?** Care Plans will be reviewed annually, at a minimum. (148)

16) **We understand that the CMO Care Manager will complete an initial assessment and a thorough assessment in order to complete a care plan. How will that plan be developed?** The Care Manager will work one-on-one with the member and/or their guardian via whatever communication means necessary (calls, visits, etc.) to ensure all the proper information is considered within the care plan. This includes coordination with the Waiver & Community Mental Health Center (CMHC) Case Managers as well. Open communication will be the key to the success of the plan. (110)

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Care Select

Contact Information

17) **Where can I find additional information?** Care Select Helpline 1-866-963-7383 or ADVANTAGE 1-800-784-3981 or MDwise 1-866-440-2449 or http://www.indianamedicaid.com/ihcp/CareSelect/cs_index.asp.

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General Information

18) **What is Care Select?** *Care Select* is a new care management program created by the Indiana Family and Social Services Administration (FSSA) to serve Hoosiers who are aged, blind or disabled. *Care Select* will tailor benefits to people who are aged, blind or disabled more effectively, improve the quality of care and health outcomes, control the growth of health care costs and provide a more holistic approach to member's health needs.

19) **What services are included in Care Select?** Care Coordination, which provides individualized services as well as assistance in gaining access to needed medical, social, education and other services; Disease Management, based on program population as well as specific targeted diseases; and Utilization Management, which ensures appropriate use of facilities, services and pharmacy.

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Indiana Care Select

20) **How do I apply for Care Select?** The Office of Medicaid Policy and Planning (OMPP) finances basic, cost-effective medical health coverage programs for low-income residents of the state of Indiana. This is done in accordance with state and federal requirements and at a reasonable cost to Indiana's taxpayers, by providing insurance coverage for health care and making timely and accurate payments to providers of health care services. Eligibility for Medicaid is determined using a two tiered process. First the applicant would have to be determined financially eligible for the Medicaid program. If the applicant met the financial requirement, then the applicant would be evaluated for participation in an Aid Category with the Medicaid program. An example of an Aid Category would be a child from 1-5 could be eligible for the CHIP program. In summary, an individual applies for Medicaid, not a specific program. (125)

21) **What is the difference between a Care Manager and a Case Manager?** Care management is an overall, holistic view of an individual's needs, including medical, social, and mental health needs. Case management is the array of services offered to our home and community based services waiver population to oversee home based services. In the instance when a Care Select member may also be receiving case management services, the care manager associated with Care Select will work with the member's case manager to ensure that the member is also receiving assistance with medical and mental health services. The care and case managers will not be duplicating services to the member, but rather complementing each other's services. (38)

22) **What does "specialist" mean in the Care Select Program?** A complete list of provider types and specialties, including descriptions and enrollment criteria is listed in Chapter 4 of the Indiana Health Coverage Programs (IHCP) Provider Manual. (http://www.indianamedicaid.com/ihcp/Publications/manuals.htm) In general a specialist is any provider not defined as a "PMP". A PMP is defined as: general practice, family practice, general internal medicine, general pediatrics, and OB/GYN. In addition any specialty provider can be a PMP if they enroll and if they meet all of the requirements of the PMP. (48)

23) **Will a person answer the Care Select Helpline and CMO contact numbers or will it be an automated phone tree?** There will be a phone tree when a member or provider uses the various contact lines. However, each member and provider will have the ability to reach a live person as well. (51)

24) **Why are 'Duals' carved out of Care Select?** Duals are eligible for additional resources as Medicare recipients. The Duals are being moved to Fee-for-Service (FFS) because they will be included in a new pilot project related to Special Needs Plans (SNPs), which puts focus on the unique business and care needed for these patients. (76)

25) **Why did the State choose two CMOs rather than only one?** The two reasons are competitive services and membership choice. (42)

26) **Are dental and vision services covered in the Care Select program?** Some services will be self referral and will not require PMP authorization, including podiatry, chiropractic, mental health, dental, vision, family planning, HIV/AIDS targeted case management, immunizations, diabetes self-management, and pharmacy. (47)

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Data Access

27) **Are the CMOs systems interfaced? Can providers interface with or access those systems?** The State's goal is to have a summary of each care plan which will be deposited in the Indiana Health Information Exchange. From the Exchange, information can be accessed electronically. Access for families is a long term goal, but simply is not possible at this time. ADVANTAGE and MDwise will have web links available as well. (102)

28) **Will providers have access to the CMO Care Data?** The CMOs will allow access to the Care Plans for providers, within HIPAA requirements. In the future providers will also be able to give input to the Care Plans via the web; however, they will not be able to change the actual Plan. (59)

29) **Will Care Select eventually have one unified medical chart per patient?** The Director of OMPP indicated that a unified medical chart is a goal of the Care Select Program, but that it will take a year or so to accomplish. However, in the meantime, the Care Plan will be 'email-able' to ease recordkeeping. (60)

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Enrollment

Letters

30) **Which enrollment letter did patients who are in the Waiver Program and Dual Eligible receive?** The Dual Eligible Letter was sent to members who are dual eligible and on a waiver (27)

31) **Which enrollment letter did patients on the "Waiting List" receive? And, which enrollment letter did members who have primary private insurance receive**? If the member is not on a waiver or dual eligible, they received the Care Select member letter. (28 & 30)

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Members

32) **Where should members call to verify whether their provider is a member of a CMO?** Members can call the Care Select Helpline 1-866-963-7383 or ADVANTAGE 1-800-784-3981 or MDwise 1-866-440-2449.

33) **Will Care Select members receive a new membership ID# and/or member card?** Members will retain their same Hoosier Health Card and will have the same ID#. The CMOs will also send an ID: ADVANTAGE will issue cards; MDwise will issue magnets. (91)

34) **Can parents choose the PMP for children who are members of Care Select?** Yes. (134)

35) **How often can a member change PMPs?** Members can change their PMP once a month. (135)

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36) **Can the State change a member's PMP if the PMP is non-responsive?** The CMOs operate under performance measures which include ensuring that all members visit with their PMP at least once a year. If a PMP is not meeting the measure, the CMO will respond accordingly. In the Care Select Program, the State will not be automatically changing anyone's PMP without first notifying the member affected. (143)

37) **Can a member ask to be reassigned?** Yes, members can ask to be reassigned at any time. Reassignments will be processed once a month. Advocates, with legal rights on behalf of the member, may request reassignment as well. Additionally, members request a change of PMP within their CMO more frequently if needed. (12)

38) **What will happen if a member's PMP drops out of the program? How and to whom will it be communicated?** The CMO will send out a letter to all members that could be affected by the change. In addition, outreach will be made to the provider to attempt to keep them in the program. If they decide to leave, each member affected will be contacted to find a suitable replacement. In addition, their current PMP must continue to provide all service for 30 days. (46)

39) **How soon will the new PMP assignments and PA forms for Care Select be available online?** The PMP information and PAs for Care Select are now available online. (139)

40) **If a member looses Medicaid while they are in Care Select, how do they re-enroll?** The member would have to re-enroll in Medicaid and, once accepted, re-enroll in Care Select. (140)

41) **Where does a member call if they are unhappy with their CMO?** A member can file a grievance with the CMO or contact the enrollment broker to request a change in their CMO. If a member is not satisfied with the established process, they can contact the Care Select Program directly at careselect@fssa.in.gov. (52)

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Providers

42) **Where are the applications for providers to enroll in the CMO?** Providers can go to IndianaMedicaid.com to secure the overall IHCP application. If the provider is already an IHCP registered provider, they can simply contact the CMO(s) of their choice and sign the appropriate Care Select Program Addendum. (56)

43) **Where can providers find the benefit plan?** It is the same as the Medicaid Select benefit plan. Refer to the Care Select web page at http://www.indianamedicaid.com/ihcp/CareSelect/cs_index.asp. (84)

44) **Can providers enroll with both CMOs?** Yes, providers can enroll with one or both CMOs. (108)

45) **If a provider is already contracted with MDwise or ADVANTAGE in any capacity, what do they need to do for the Care Select Program?** Care Select is a new and separate program. Therefore, providers must enroll with the CMOs by signing a Care Select Addendum to enroll as a Care Select provider. (64)

46) **Can providers outside of the Central Region enroll early?** While the team has been focused on enrolling providers in the Central Region who were affected by the 11/1/07 implementation date, it is certainly acceptable for providers elsewhere in the state to enroll early with the CMO of their choice. (57)

47) **Can a provider enroll with a CMO in order to serve one specific patient?** Any IHCP PMP can enroll as a provider in Care Select regardless of their panel size. (29)

48) **Do specialists have to be enrolled with a CMO? Can a specialist, for example a psychiatrist, be a PMP?** Specialists are available to members via an open network arrangement. If a psychiatrist wants to operate as a PMP, they would contact the CMO with which they would like to participate and follow the enrollment process accordingly. (13)

49) **Is there a limit on the size of a PMP's Care Select panel?** Care Select does not dictate panel size. The program simply needs more doctors willing to see Medicaid patients. There is hope that the increased administrative and visit fees will improve the situation. (79)

50) **What happens if a PMP drops out of the program? How and to whom will it be communicated?** The CMO will send out a letter to all members that could be affected by the change. In addition, outreach will be made to the provider to attempt to keep them in the program. If they decide to leave, each member affected will be contacted to find a suitable replacement. In addition, their current PMP must continue to provide all services for 30 days. (46)

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Statistics

51) **How large is the Care Select target population within the state?** There are 70,000 total targeted members statewide. (3 & 39)

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Payments and Billing

52) **What are the new Care Select Program reimbursement levels for providers?** PMPs will receive a $15 administrative fee per member per month. Services must be billed using HCPCS99211 SC - Office or other outpatient visit for the evaluation and management of an established patient. Care Select PMPS are reimbursed $40 for the care coordination meetings, which can occur twice per rolling calendar year. All services are billed to the state and paid based upon the existing Medicaid fee schedule. (41)

53) **What do the CMOs get paid in the new Care Select Program?** The CMO receives a per member per month administrative fee of approximately $25 for providing services. (44)

54) **Will there be denial of claims?** Claims could be denied for miscoding of submission or for lack of authorization. However, there is not an expectation of an increase in denied claims. (96)

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Pharmacy

55) **Will pharmacy remain as it is today? Can members continue to get prescriptions from their current pharmacy or mail in provider?** Yes. (70)

56) **What are the Care Select CMOs planning regarding psychiatric meds?** The Care Select program will abide by the state's Fee-For-Service (FFS) prescription drug list. Any type of intervention or edit that the CMO would like to pursue would need to be presented and approved by the Drug Utilization Review (DUR) Board as well as any other relevant committees. (20)

57) **How will Care Select affect access to medications?...More specifically, psychiatric medications?** Care Select will follow all Medicaid rules regarding the prescription of medication. Nothing will change for its members. (120)

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Prior Authorizations (PAs)

58) **Will PAs carry over to the new CMO**? Yes, all current PAs, to include those less than 30 days old, will carry over to the new CMO. In addition, the rules surrounding PAs will remain the same in Care Select as they were in Medicaid Select. (106)

59) **Will PAs still be available online?** Yes (136)

60) **Will the PA forms remain the same?** Yes, the PA forms will remain the same and will be the same for both CMOs. (133)

61) **How soon will the new PMP assignments and PA forms for Care Select be available online?** The PMP information and PAs for Care Select are now available online. (139)

62) **Will referral codes or PA codes change with Care Select?** The requirements and codes for referrals and PAs will remain the same under Care Select as they were in Medicaid Select. The key difference is where the referrals and PAs will be submitted. Under Care Select, the PAs will be submitted directly to the appropriate CMO. (92)

63) **Will current Home Healthcare Authorizations remain as they are today?** Yes, the general process will remain the same as it is today, with the exception that you will contact the appropriate CMO for authorization. The Web interChange will remain in place as an option to submit PA requests online. (67)

64) **Can providers still submit multiple PAs at one time? For example: the same service six months out.** The CMOs are following all current PA rules and utilization management rules. (85)

65) **Will PA hearings and appeals still be handled by FSSA?** Hearings and appeals will be handled by the FSSA hearings and appeals office. The PA vendor who denied the request will be involved in the

hearing and appeals process. The hearing will still occur in front of an Administrative Law Judge. The policies and procedures regarding Hearing and Appeal of the Administrative Review Process will remain the same as they are currently published. (69)

66) **Why is ADVANTAGE processing PAs for the whole program? What protection is there for the MDwise patient in this scenario?** Each CMO will be responsible for processing medical service PA requests and updates for members assigned to their organization at the time of request. Additionally, ADVANTAGE will be responsible for processing PA requests and updates for all Traditional Medicaid FFS members. (43)

67) **When will Medicaid Rehabilitation Option (MRO) services be rolled into the PA process? Is it still 7/1/2008?** The Director of OMPP indicated that there are some pending legislative changes that may impact the MRO causing a later date, perhaps 1/1/2009. Things are uncertain until the outcome of the legislative changes is known. (107)

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Transportation Services

68) **Will transport providers be responsible for knowing whether the member is with ADVANTAGE or MDwise?** If the transportation service requires prior authorization then the provider is held responsible for checking eligibility and submitting the PA to the appropriate PA vendor. All transport bills will be submitted to EDS. (97)

69) **Is transportation included within the Care Plan?** Yes, transportation services are included in the Care Plan. (105)

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Waiver Members

70) **Will Care Select replace the need for Waiver Services?** No, Care Select will not replace the Waiver Program. (149)

71) **Will Waiver Case Managers still exist?** Yes, Waiver Case Managers will still exist. They will be included in the Care Select care coordination. Care Managers will not duplicate the efforts of the Waiver Case Managers, but rather complement those efforts when needed. (147)

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